|  |  |
| --- | --- |
| Notes from Senate Council Meeting |  |
| Held on 27th September 2018 |
| In Taunton Rugby Club |
|  |  |

Meeting Notes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | | **Action** | |
| **1** | **Welcome, introductions and business items** | |  | |
|  | Round table introductions – attendance and apologies listed above. SP welcomed SBerry on her return.   * Council members were asked to declare any potential conflicts of interest in relation the topic which were recorded. * SPearson thanked members that have already contributed to the Clinical Review programme and gave an update about recent and upcoming clinical reviews, that will require members to participate and encouraged volunteers to contact RPerry or TTrim  |  |  | | --- | --- | | **STP** | **Update** | | Bath Maternity | CRP complete | | Gloucestershire | Likely to need a further CRP  Progress delayed | | Weston | CRP planned for end of November | | Mental Health Services in Bristol, Bath, North Somerset | Will require a CRP | | Cornwall | Senate invited to early stakeholder meetings | | Devon | Will require CRP.  Timeline not agreed | | Somerset | Will require CRP  March or July 2019 | | Bristol –neonatal services  ( 2 Centre – to include Plymouth) | Will require a CRP.  Timeline not agreed |  * Notes from 17th July Senate Council meeting required an amendment to section eight regarding the Citizens’ Assembly presentation and individual contributions at that meeting.   **Action: TTrim**   * The recommendations from the 17th July Council meeting were distributed. * SPearson outlined that in looking at proposed dates for 2019 Senate Council meetings we will consult with members whether to offer some Council dates on a Tuesday to allow members who find it difficult to attend on a Thursday because of Clinical commitments.   A survey for attendance will be sent out to members.   * SPearson welcomed 2 new Council Members - Dr Rob Dyer and Dr Amelia Randle. * SPearson sought Council permission to invite a new Clinical lead voting member from West of England AHSN – Anne Pullyblank; and   one Clinical lead from NICE as an attender – Jane Jacobi.  Paperwork welcoming them to the Senate Council will be sent to them.   * 2019 dates for Senate Council Meetings. A Survey Monkey survey will be sent out to Council Members to ask them for their availability on either a Tuesday or Thursday of the relevant month to ascertain if offering a date other than a Thursday would open up attendance for members with clinical commitments on a Thursday. | | **RP**  **TT** | |
| **2** | | **Scene Setting: The Bowel Cancer Pathway and Delivery Challenges** | |  |
|  | | **The aim of this meeting is to deliberate “*To what extent are providers in the South West able to deliver the national commissioning pathways for colorectal cancer patients?***  ***What are the key areas for pathway redesign and provision of service that will improve the quality of experience & timeliness of treatment for patients across the region?”***  SPearson outlined that this topic was driven from within Council membership around the challenges that impair the consistent rollout of the National Pathway Guidance and the need to embrace and implement the guidelines given the challenges, locally. What could we recommend to Cancer Networks to result in a consistent pattern of delivery?  Input from colleagues across the South West was excellent prior to the meeting and a need to discuss the same aspect across other Cancer Pathways became evident but imminently the focus needed to be in regard to the Colorectal Cancer Pathway.  Funding through the Cancer Network to effect changes could facilitate delivery of actual changes. Melanie Feldman ( Colorectal Surgeon) and Jonathan Miller ( Cancer Alliance) were particularly thanked for their contribution to this meeting | | **All** |

|  |  |  |
| --- | --- | --- |
| **2.1** | **Colorectal Cancer : New guidelines for a quality service** |  |
|  | MFeldman presented under the above title.  Affecting change within your own Trust is challenging enough let alone regionally.  Current ‘picture’ of Colorectal Cancer outcomes for UK appear good but are lower in comparison with other international net survival outcomes for e.g. Europe and up to 15% less net survival in the UK than Australia. The difference in outcomes are most likely due to late presentation.  Need for early diagnosis leads in the initial affecting of changed outcomes. Supported by more screening at a lower threshold of presenting symptoms. In England there is an increased rate of emergency presentation with about 24% of patients diagnosed following admission via Accident and Emergency (A&E) departments. More than half these patients have late stage disease.  Achieving earlier diagnosis will require improvements in participation in screening by:   * harnessing the ability of GPs to promote increased uptake of the National Bowel Cancer Screening Programme (NBCSP) * a lower threshold for referral for investigating patients with colorectal symptoms * expanding and making better use of diagnostic capacity.   The aim of the bowel cancer service should be to:   * prevent people from dying from bowel cancer; achieved best by early diagnosis. Where this is not possible, extend their lives. * Maintain the quality of life for people diagnosed with bowel cancer * Deliver access to the best available treatments for all patients. * Treat people safely and protect them from avoidable harm * Help patients recover from bowel cancer related illness and side effects of treatment * Deliver a positive experience of treatment and care for patients and carers – CNS support.   This is particularly difficult to deliver in the SW in part due to the large geographical spread.  In 2011 85% of patients were hitting the target of 62 days from entry into the system to undergoing relevant treatment; between then and 2018/19 less than 85% were hitting that same target and it has been a continuing downward trajectory.  NICE guideline NG12 is introduced in 2015 ( 2016 in South West).   * Categories for 2WW (Cancer Referral to Treatment Plan Protocol -Two Week Wait) made wider * Aim to investigate more people * Estimated cancer rate 3% * Previously 9-11% * Included an area ‘low risk but not no risk’ – DG30 followed on 2017   FIT testing for additional lower risk group, +FIT > 2WW  The effect of these on the system is increased access e.g. for Royal Cornwall Hospital NHS Foundation Trust it created the outcomes of:   * 2016/17 a SW Trust overspend endoscopy in overtime/outsourcing > £250k * 2017/18 financial constraints, only timetabled activity   By April 2018 :   * routine wait 30 weeks * 2WW wait 7 weeks * Surveillance 9 months later * Catch-up 2018 312 sessions £312k   This against a background of finite resources and ensuring that additional funding must not worsen one area of the service in order to improve another.  Against this background MF is looking to the Senate Council to help define improvements.  A further breakdown of the 15% difference in survival rate that is the case in Europe and Australia reveals in the UK that a third of that is due to lack of pre diagnosis, a third because more patients in the UK do not present until symptons mean they present to Emergency Services and a third present as urgent outpatient referrals.  JMiller ( South West Cancer Alliance Lead)  Colorectal Cancer: Cancer Alliance Work Cancer Alliance Work  JM continued to ‘set the scene’ in the South West emphasising that ‘stage’ intervention is a key difference in treatment in affecting the outcome. Educating people to be more self -ware and present themselves earlier in the disease; which is the trend in Europe and Australia.  For example removal of polyps is a very effective early intervention to prevent the patient from going on to develop colorectal cancer.  Since 2016, Royal Cornwall Hospital Trust has seen the percentage of patients being seen under the NG12 protocol increase by over 50% however the workload to achieve that is at 200% and even so the conversion rate is yet to translate into driving down the estimated cancer rate to 3%.  Nationally the picture is more patients are being seen and within 62 days however in the South West he population is an older, frailer patient presenting for treatment..  NICE Guidelines on Suspected Cancer published June 2015  Referral forms revised to match new criteria with a focus on increasing direct access for GPs to tests-Guaiac test (faecal occult blood testing).  However this was decommissioned as it was deemed poor quality. So no way for GPs to use this NICE recommendation locally. Then the quality of new test Faecal Immunohistochemical Test – FIT began to emerge, providing a more specific and sensitive test  Quantitative result (rather than plain +ve or –ve)  Both South West Cancer Alliances bid for and were awarded funding to implement FIT in the South West – using NG12 criteria  Service started in June 2018.  Other indications to be introduced by March 2019 in to National Bowel Cancer Screening Programme.  Threshold to be 120µg/g  Uptake likely to increase by 7% as test is more user friendly  Additional demand expected. Screening centres working through capacity plans with commissioners  Evidence suggests optimal screening detection threshold approx. 90µg/g.  FIT – Other indications; A number of studies are testing FIT in high risk patients i.e. those meeting criteria for 2 week wait referral  Non-English studies indicates this is appropriate and may reduce demand for referral by 40%  Some evidence that FIT could be used in screening programme in place of surveillance colonoscopy  FIT could have a place in surveillance following colorectal cancer.  Alliances recommend introduction of steps to allow patients to go straight from GP to test (colonoscopy, flexi-sigmoidoscopy, CT colonography)  This is in place in all but 2 South West providers  Method of triage varies (nurse vs consultant, phone vs paper, direct electronic booking by GP)  Proportion of patients triaged to specific tests or outpatient appointment likely to vary  Cohort this process applies to varies (2ww vs routine referral).  Currently a flaw in the system is if a GP refers a patient to CR Services without a FIT test having been completed is a missed opportunity as the Acute Trust cannot run a FIT Test and so a different diagnosis pathway commences. It’s essential to raise awareness and inform GPs of the benefit of offering FIT test. |  |
| **3** | **A System-Wide Approach to Long Waiters** |  |
|  | ARandle presented from a GP perspective.  The 62 Day protocol is a major driver in primary care.  2 Phases  ‘The Golden 28 days’ of cancer diagnosis.  2ww conversion rate of 10% for the sake of easy maths  By the time people are on the active cancer pathway the 28 days is over.  GPs look at the pathway in this sort of way..  As soon as we realise this person is going to need anticancer treatment and are going to count towards 62d target we think of the steps in the pathway and try to make them quicker. More access to scans, streamlining pathways; instead of thinking of each step individually. We need to “achieve” the 62 days ‘better’. AR then gave an example where the diagnosis pathway for a specific patient went horribly wrong despite following the protocol because of human error misdiagnosis due to emphasis placed on presenting symptoms against looked at against her medical background; unfortunate communication breakdowns on both sides. Patients can present in those first two weeks with both Medically Unexplained Symptoms and Vague Symptoms of Cancer at the same time, as was the case with this particular patient.  PButtle commented that he has had personal experience of communications breakdown in the system. Firstly ‘pinchpoint’ of letters generated by a Consultant back to the GP and secondly when an urgent letter to do with treatment for his ill father was delayed five days because the GP left early on a Friday and the letter remained in the Out-tray until the GP returned to work. ARandle concurred that she had instances where patients had handed her Consultants’ letters that she had not received a direct copy of prior to that.  In the South West and nationally better conversion rates lay in earlier diagnosis. 20% - 30% of Colorectal patients still present through Emergency admission.  Patients do not always feel empowered.  Image result for patient activation measure    Ten times the number of patients are entering the system who end up at the end of the pathway when a cancer is diagnosed. Many of these end up back with their GP with other health problems that require continued investigation so the capacity never decreases from a GP perspective  There is also the people who feel GPs are too busy to ‘bother’ the “ I don’t want to waste my GPs time” and so diagnosis is delayed. |  |
| **4.** | **Implementation of national changes to screening programmes – FIT 120** |  |
|  | JBolt, Head of Public Health Commissioning, NHS England South West (South) outlined an update on national rollout of FIT and the opportunities and challenges of that.  Public Health functions are set out in Section 7a which include: Cancer and non cancer screening.   * The role of NHS England –Section 7A Bowel Screening: * Commissioners of current gFOBT service * Commissioners of bowel scope screening (flexi sig) * Future commissioners of FIT 120   We don’t directly commission   * Surveillance colonoscopies (CCGs) * qFIT (Cancer alliances with CCGs)   **Opportunities**   * Better outcomes for patients with positive impacts on other parts of the cancer pathways * Whole system approach to capacity planning e.g. qFIT and symptomatic services. Shared outcomes * Training and development opportunities for staff involved in bowel screening * Opportunity for services to undertake an internal review of their capacity and operating models, look for productivity, quality and efficiency gains * Opportunity to revisit the funding formula and contract mechanisms with each provider * Financial investment available to pump prime FIT roll out * qFIT potential to unlock capacity?   **Challenges**   * Accuracy of the modelling assumes parameters are robust and will occur. How can we plan for variance? * Limited modelling to date on impact on pathology and radiology (must not overlook this) * No immediate clarity on what phasing would look like from a hub perspective * Surveillance cohorts currently paid for by CCGs * Workforce, significant implications for some providers with ongoing training and recruitment planning * Additional equipment requirements and physical space to run additional lists that require capital funding * Diagnostics services in a number of providers already stretched and waiting times not being achieved especially in symptomatic services * Potential to create imbalance between screening and symptomatic services in terms of outcomes for patients * No national funding model or financial allocation for FIT * Most providers working to a population based funding formula with a block contract * qFIT impact could be negative?   **Nest steps**   * Validating the capacity demands with providers, ensure we have captured and quantified all impacts, risk assessments to assure national oversight processes * Review provider mobilisation and investment plans, agree pump priming funding where suitable. * Agree contracts and pricing with screening centres for the additional expected activity * Critical dependency is the timing and outcome of the national procurement for the FIT testing kits, sample hardware and IT for the hubs to begin phasing the invitations * Continue to work with CCGs on whole pathway capacity plans to mitigate any unintended consequences from FIT120 * Continue to work with stakeholders including Cancer Alliances to ensure clear and consistent messaging and identify any areas for complimentary work to improve patient outcomes |  |
| **5** | **Self-Assessment against guidance in Devon** |  |
|  | BParker (Head of Commissioning-Planned Care at South Devon and Torbay CCG) provided a tabled Audit Tool “IMPLEMENTING A TIMED COLORECTAL CANCER DIAGNOSTICS PATHWAY – BASELINE AUDIT TOOL – SUMMARY ANALYSIS” for pre-reading ahead of the Council meeting. The Tool scrutinises if the planned protocol pathway steps are being met at each stage across the Acute Trusts in South West (South) and to what extent and what identified actions are to be put in to place to improve any shortfalls. It provides both a “Place Plan” and a “System Plan” that can be continually updated.  By using the template format it has helped to identify and highlight specific areas that are under pressure and to arrange meetings specific to addressing those issues at the earliest opportunity. There are specific Workforce aspects that prevent the system plan working optimally; e.g. that PHNT had 6 vacancies within the Endoscopy Department for 1 year at one point.  This strategic plan across Devon is informed by continual research and compilation of data and although a relatively simple technique it demonstrates that whole systems are undergoing a total challenge and not just pockets in isolation. This crystalises where those problems occur to then be focussed on.  This is against a picture of Workforce challenges nationally for Endoscopy Departments which DHalpin commented on at the same juncture of asking can this Plan Tool be rolled out to other Cancer Pathways which are failing and which too require solutions of their own. It is important that any increased funding is new and not redirected from other services.  MFeldman commented that she attends various meetings all with a different focus for consideration such as Commissioner decision maker viewpoint versus the Clinician’s viewpoint. Communications – meetings need to be improved conversations about detail and at the same time generic. The process is very proactive with Clinicians feeding in e.g. if a discussion is about scanners the location, age of scanner is known.  Scanners can operate 7 days a week if the requisite staff was available e.g. between Feb and May 2018, 95 hrs of potential scanning were lost due to maintenance; FIT120 cannot work optimally unless there is the workforce capacity to meet it. |  |
| **6** | **HEE workforce update** |  |
|  | **DSprague,** LETB Director South West at Health Education South West presented Implementation of the National Cancer Workforce Plan (an Aligned Cancer Plan [HEE]).  The National Cancer Plan commenced in 2015 (Phase 1) HEE’s Cancer Workforce Strategy: Dec 2017 – Mar 18 focuses on 2018 -2021.  Phase 2 is imminent but the launch is delayed by the recently announced NHS 10 Year Plan.  Two key areas for the plan are Clinical Radiology and Clinical and Medical Oncology.  A phase 2 cancer workforce plan will take a medium to longer term view on the workforce. This will include additional information outlining the challenges for the nursing workforce, including Cancer Clinical Nurse Specialists. (HEE working in conjunction with Macmillan Nurses to underpin the training required for the role).  To improve the overall supply HEE and its Arms Length Body partners need to undertake a series of actions to improve the supply by:  Reducing ‘attrition’ from training and improving the numbers and speed of transition into NHS employment (HEE role)  Improving retention of existing NHS staff, postponing retirements, recruiting into the NHS from non-NHS sectors of employment and international recruitment. (mainly employer role).  In Phase 1 HEE is working with six Cancer Alliances in the south of England (two in the SW) to develop local/ regional workforce plans.  Cancer Alliances have no statutory powers re workforce; thus more must be done to align plans with STPs/ICS and maximise levers across the system. The workforce planning process provides focus for necessary conversations, raising the profile of workforce planning with Alliance partners and beyond e.g. ALB South Cancer Programme Priority Board leads and with their agreement HEE set up and DS Chair’s a South Workforce sub-group. This gives workforce focus, supporting the HEE and NHSE/I ambitions.  International recruitment will contribute the single greatest contribution to workforce growth…BUT maximising uptake of reporting radiography training.  Utilising a range of approaches to recruit into consultant posts, including international recruitment within Clinical Radiology and Clinical and Medical Oncology. Within Midlands and East region there is a move away from traditional clinical oncology posts to radiation oncology posts with a view to making posts attractive.  Current plans include;   * Training to provide 200 more clinical endoscopists by 2020 * 150-300 Diagnostic Reporting Radiographers by 2020 (already secured 2018-19 places)   (7 month training programme for each; first cohort trained within 12 months)   * 150 nurses and AHPs to complete ‘Macmillan Explore’ - by the end 2018 * Competency framework for CNSs and skills support programme   The HEE funding offer includes Programme costs and some travel costs.  Training package of £15,000 per trainee for employers to use to help release staff/obtain supervision for the 200 procedures necessary to qualify.  An update for Clinical Endoscopy training in the South West from previous cohorts reveals that out of 18 Applicants, 10 have undertaken the training ( 7 applications failed and 1 non completer).  There is also a programme to upskill current workforce in the SW 10 ‘trainees’ have engaged with that across NBT (2),TST (2), UHBT (2), RD&E (4).  Continued work going forward is further work at system level to link existing retention and attraction actions into cancer specific workforce (“bucket”).  Configuration of South Regional Cancer Workforce Priority Group (CWPG) is underway. Chaired by HEE (Cancer SRO south) and reporting into the full South Cancer Board.  Continuing to build on the collaborative approach with medical colleagues to identify realistic education potential actions (pipeline). Those actions will be part of the CWPG work-streams.  Continue to support the alignment of STP/Local Workforce Action Boards service planning with workforce intelligence to inform focus areas in phase 1, and leading to development of phase 2.  Raised Reporting Radiographer funding options with cancer Alliances and employers. Similar to follow around Endoscopy and FIT.  A view that this is still too little and too late to avert a problem in workforce availability to allow for sustaining the current workforce levels and increasing it in the near future – there is not a quick fix to deal with the pressures and new potential pressures on Endoscopy departments.  Next steps going forward:   * Emphasis on moving some functions from Secondary care to Primary care * sustainability and transformation partnerships (STPs) could look at the ‘spread’ of trained Radiographers to explore greater mobility of the workforce.   The new role of Physician associate intended to support doctors in the diagnosis and management of patients could be based in a GP surgery or be based in a hospital. Challenges to this are that the workforce prefer to be based in Acute Trusts as opposed to General Practice.  Also that GPs currently do not ‘understand’ are not familiar the roll out of training for this role having been involved only in junior doctor training to date.  There is also an aspect around prescribing – not currently included in generic nurse training but CCGs are exploring funding and role out of non medical prescribing e.g. Clinical Pharmacist role. |  |
| **7** | **Citizens’ Assembly – Joanna Parker, CA Chair** |  |
|  | JParker gave a brief outline of the constitution of the CA and their role in contributing to Council debates and conferences. At Assembly meetings the 13 Healthwatch members ‘de-construct’ the “Question posed for Council discussion (which is compiled to be aimed at clinicians and their vocabulary).  JParker relayed a personal experience, as a family member of a patient (her husband) accessing the Colorectal diagnosis pathway very recently. From this viewpoint she researched as much as she could and ensured that she read all of the pre reading in an attempt to pull out a Mind Map of considerations.  Joanna’s husband is a very physically fit man in his 70s and had not previously had to undergo any medical intervention for health issues.  The entry into the system began with a request to repeat the Bowel Cancer Kit that he was sent as being in the catchment group for this screening. That done he left the country for a planned trip abroad. On his return he had been contacted to undergo a colonoscopy procedure.  Joanna experienced for the first time his unexpected reaction of “…..falling apart” at that news. It was a Clinical Nurse Specialist who steadied his response won him over to definitely going through with the test and helped prepare him for what was entailed and what to expect.  The resulting outcome was exactly what they both wanted; as the feedback from the test a very unambiguous healthy colon.  So Joanna’s Mind Map considerations from this experience are:   * Please involve patients in the planning, through good, clear communication; listening, advocacy and written * What communication is available from both secondary and primary care ? Was it prepped including a patient viewpoint? * Support for carers, family * Compassionate care * Full understanding of both the physical and psychological impact * Equity of access to care (locally) * Managing side effects   It’s almost 25 years since the Calman-Hine report was published; it examined cancer services in the United Kingdom, and proposed a restructuring of cancer services to achieve a more equitable level of access to high levels of expertise throughout the country, its main recommendation was to concentrate care into the hands of site-specialist, multi-disciplinary teams as best practice. From Performance Management from every provder the need for the role of a Lead Cancer nurse became an evident.  Current challenges for the service are adequate manpower, adequate capacity and local distortion.  From today’s presentations and discussion Joanna has also flagged the need to ensure that there isn’t inequality in the parity of disciplines; that there “isn’t robbing Peter to pay Paul”.  How can demand be reduced for these overworked departments such as Endoscopy; better screening should help to alleviate that but it is not a quick fix.  Systems are made up of systems – sustainability and transformation partnerships (STPs) are designed around the needs of whole areas, not just individual organisations; they are starting to look at that aspect, how it all works/changes.  Colorectal Surgeons availability 24/7 is no longer the reality for the Emergency Services (in terms of delivering surgery). |  |
| **8** | **Group work: Diagnostics and Workforce.** |  |
|  | The meeting attendees split into 2 groups to consider the above issues to facilitate the coalescing of recommendations. ( see Recommendations from the South West Clinical Senate Council meeting on 27th September 2018 document. |  |
| **9** | **Conclusions and AOB** |  |
|  | **Future Meeting Dates - 2019**Pending the outcome of the survey responses from Council members and their preference for alternating weekdays for the meeting rollout – the 2019 dates will be circulated shortly. | **TT** |

**2018 Meetings: 29th November**

**Present:**

|  |  |
| --- | --- |
| Rachel Perry | Sunita Berry |
| Derek Sprague | Sally Pearson, Chair |
| Marion Andrews-Evans | Mary Backhouse |
| James Bolt | Helen Dunderdale |
| Joanna Parker | Melanie Feldman |
| Caroline Gamlin | Bettina Kluettgens |
| Ben Lankester | Peter Buttle |
| Nick Pennell | Joanna Parker |
| Nadar Francis | David Halpin |
| Gilly Gotch | Nina Kamalarajan |
| Lynne Kilner | Beverley Parker |
| Jon Miller | Dave Partlow |
| Tim Platt | Maggie Rae |
| Amelia Randle | John Renninson |
| Sally Rickard | Peter Rowe |
| Derek Sprague | Trish Trim |
| Ruth Wilcockson | Julie Burton |
| Aileen Fraser | Andrew Tometzki |
| Paul Winterbottom | Anne Pullyblank |

**Apologies:**

|  |  |
| --- | --- |
| Tariq White | William Hubbard |
| Diane Crawford | Vaughn Lewis |
| Jane Mitchell | Andrea Merrison |
| Mark Stone | Robert Dyer |
| Paul Eyres | Nick Kennedy |
| Peter Bagshaw | Sara Evans |
| Bruce Laurence |  |